Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

P.O. BOX 8747, BOSTON, MA 02114-8747
617.727.2310 www.mass.gov/gic

Springfield Enrollment Form – Medicare and Non-Medicare Combination Coverage

Insured's GIC-ID (usually Soc. Sec. #) Sex: Male ☐
_____ - _____ - _____ Female ☐ Date of Birth ___/____/____

Name (Last) _____ (First) _____ (MI) _____

Address _____

City _____ State ____ Zip code _____

Home Phone _____

Complete this section if you as the insured are under age 65 and not enrolled in a Medicare plan and your spouse and/or dependent is over age 65 and enrolled in a Medicare plan.

_____ I want to enroll in the (check one):
☐ Commonwealth Indemnity Plan Basic with CIC (Non-Medicare).
☐ Commonwealth Indemnity Plan Basic without CIC (Non-Medicare)
☐ Commonwealth Indemnity Plan Community Choice
☐ Commonwealth Indemnity Plan PLUS
Please enroll my spouse and/or dependent in the Commonwealth Indemnity Plan Medicare Extension (OME) (check one):

_____ I want to enroll in the Harvard Pilgrim Independence Plan. (Please enroll my spouse and/or dependent in the Harvard Pilgrim First Seniority Freedom Plan. I will contact Harvard Pilgrim and complete the Medicare enrollment form.)

_____ I want to enroll in Navigator by Tufts Health Plan. Please enroll my spouse and/or dependent in:
Check one: Tufts Medicare Complement _____ Tufts Medicare Preferred _____
(I will contact Tufts and complete the Medicare enrollment form.)

_____ I want to enroll in the _____HMO Plan.
(Please enroll my spouse and/or dependent in the HMO's Medicare Plan. I will contact the HMO Plan and complete the HMO's Non-Medicare and Medicare enrollment forms.)

Complete this section if you as the insured are over age 65 and enrolled in a Medicare plan and your spouse and/or dependent is under age 65 and not enrolled in a Medicare plan.

_____ I want to enroll in the Commonwealth Indemnity Plan Medicare Extension (OME) (check one):
☐ with CIC
☐ without CIC
Please enroll my spouse and/or dependent in the (check one):
☐ Commonwealth Indemnity Plan Basic (Non-Medicare).
☐ Commonwealth Indemnity Plan Community Choice
☐ Commonwealth Indemnity Plan PLUS

(options and form continued on page two)

Complete this section if you as the insured are over age 65 and enrolled in a Medicare plan and your spouse is under age 65 and not enrolled in a Medicare plan *(options continued)*

_____ I want to enroll in the Harvard Pilgrim First Seniority Freedom Plan.
(Please enroll my spouse and/or dependent in the Harvard Pilgrim Independence Plan. I will contact Harvard and complete the Medicare enrollment form.)

_____ I want to enroll in (check one) ☐ Tufts Medicare Complement ☐ Tufts Medicare Preferred
(Please enroll my spouse and/or dependent in Navigator by Tufts Health Plan. I will contact Tufts and complete the Medicare enrollment form.)

_____ I want to enroll in the _____HMO Medicare Plan.
(Please enroll my spouse and/or dependent in the Non-Medicare HMO Plan. I will contact the Plan and complete the Medicare and non-Medicare HMO enrollment forms.)

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for all children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. You are required to complete a student or handicapped applications for any dependent you are listing below who is age 19 or over. Attach separate sheet if additional space is required.

Last Name First MI Relationship Date of Birth Sex Social Sec. #

_____

_____

_____

_____

_____

SPOUSE INFORMATION

Is your spouse employed? Yes ☐ No ☐ Name of employer_____

Address of employer_____

Is your spouse covered under his/ her employer's group health insurance plan? Yes ☐ No ☐

Name of Insurance Company _____Policy/Certificate # _____

Address of Insurance Co._____ _____

Are you and/or your children covered under your spouse's health insurance plan? You: Yes ☐ No ☐ Children: Yes ☐ No ☐

Is your spouse enrolled in Medicare? Yes ☐ No ☐ If yes, Medicare claim number _____

FORMER SPOUSE

Name _____Social Security Number _____Date of Birth _____ Date of Divorce _____

Address _____
Street City State Zip

Is your former spouse employed? Yes ☐ No ☐ Name of employer: _____

Is your former spouse covered under his or her employer's group health insurance plan? Yes ☐ No ☐

Signature of GIC Insured: _____Date:_____

Print name of GIC Insured: _____ Print Insured's Soc. Sec. #_____

RETIRED ENROLLEES: RETURN BOTH PAGES OF COMPLETED FORM TO YOUR GIC COORDINATOR: BENEFITS OFFICE, 36 COURT ST., SPRINGFIELD, MA 01103

FORM SPRMIXED 9/06